

HIV ANTIBODY TEST

CALIFORNIA STATE DEPARTMENT
OF HEALTH SERVICES

LOCAL LABORATORY NUMBER

Unique Office
of AIDS Client
Number



999-9999-9

SPECIMEN DATE:

(mm/dd/yy)

RETURN APPOINTMENT

DATE: (mm/dd/yy)

GENDER: ☐ (1) MALE ☐ (2) FEMALE ☐ (3) M-F ☐ (4) F-M

DATE OF BIRTH:

(mm/dd/yyyy)

RESIDENCE COUNTY:

RESIDENCE ZIP CODE:

LABORATORY NAME & ADDRESS:

CLINIC/SITE NAME, ADDRESS, & PHONE:

CONFIDENTIAL TESTING USE ONLY

LAST NAME:

SSN: (last 4 digits,
0000 if unknown)

SOUNDEX CODE:

RAPID TEST USE ONLY

LOT NUMBER:

EXPIRATION

DATE: (mm/yy)

COUNSELOR/
TECH INITIALS:

SPECIMEN: ☐ (1) ORAL ☐ (2) FINGER STICK ☐ (3) VENIPUNCTURE

LABORATORY USE ONLY

ELISA: ☐ (1) REACTIVE ☐ (2) NON-REACTIVE

SUPPLEMENTAL TEST PERFORMED:

☐ (1) IFA

☐ (1) REACTIVE

☐ (2) NON-REACTIVE

☐ (3) NONSPECIFIC/
UNSATISFACTORY

☐ (1) WESTERN BLOT

☐ (1) REACTIVE

☐ (2) NON-REACTIVE

☐ (3) INDETERMINATE

SUMMARY INTERPRETATION:

☐ (1) HIV ANTIBODY DETECTED

☐ (2) NO HIV ANTIBODY DETECTED

☐ (3) INCONCLUSIVE - SUBMIT ANOTHER SPECIMEN

☐ SEE ENCLOSED NOTE

NOTE:

DATE RECEIVED

BY LAB: (mm/dd/yy)

DATE REPORTED:

(mm/dd/yy)

BEGIN TEST

TIME

TEMPERATURE

☐ AM

☐ PM

° F

END TEST

TIME

TEMPERATURE

☐ AM

☐ PM

° F

RESULT: ☐ (1) PRELIMINARY POSITIVE (indicate confirmatory specimen)

☐ (2) NEGATIVE

☐ (3) INVALID, reason:

CONFIRMATORY SPECIMEN GIVEN: ☐ (1) YES ☐ (2) NO

LAB SPECIMEN

SPECIMEN: ☐ (1) ORAL ☐ (2) FINGER STICK ☐ (3) VENIPUNCTURE

RETURN THIS COPY TO TEST SITE

DHS 8257 (9/03)